DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **06/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CENTER FOR REHABILITATION AND HEALING LLC	**932 BADDOUR PARKWAY** **LEBANON, TN 37087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS During the follow up survey conducted on 06/10/2019, all previously sited Federal Deficiencies had been corrected.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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OMB NO. 0938-0391

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: NFPA Type V(000), V(111), II (222) limited plans on site Constructed: 1960's + Sprinklered: Yes A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 05/06/2019. During this Life Safety Survey Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). * All damaged, painted, or corroded sprinklers shall be replaced in accordance with NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). *All sprinklers deficiencies shall be corrected in accordance with NFPA 13, Standards for the Installation of Sprinkler Systems (2010 Edition) and/or NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition)	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adrienne Crider
TITLE: Administrator
(X8) DATE: 5/23/19

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K 222	Continued From page 1 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222	K222 - Egress Doors 1. **Corrective Action:** ADM or designee placed the missing key in the key box on the rehab courtyard wood gate. Maintenance staff inserviced by ADM or designee to ensure keys are placed within the key boxes. 2. **Identifying other residents with potential to be affected:** Residents in the secured unit have the potential to be affected. 3. **Measures or Systemic Changes:** ADM or designee checked any other key boxes on egress gates to ensure keys were present. 4. **How corrective action will be monitored:** ADM or designee will do weekly audits x 4 weeks of key boxes. The ADM or designee will then do monthly audits x 2 months. The results from the audits will be presented to the QAPI committee for further review. Any further issues or concerns will be addressed by the QAPI committee.	6/10/19

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K 222	Continued From page 2 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain egress doors. This deficiency affected 1 of 16 smoke compartments and 32 residents. The findings include: Observation on 05/06/2019 at 6:39 AM, revealed the rehab courtyard wood gate was locked with key access and no key available. NFPA 101, 19.2.2.2.5.1 (2012 Edition) The Maintenance Director and Facility Administrator was present for the findings and acknowledged them during the exit conference on 05/06/2019.	K 222		

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K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and document review the facility failed to maintain the sprinkler system. This deficiency affected all smoke compartments and all residents. The findings include: 1. Observations on 05/06/2019 between 6:49 PM and 8:35 PM revealed painted or corroded fire sprinkler pendants in the following areas: a. RM 19 (painted) b. RM 15 bathroom (painted) c. ICF Dining room multiple (corroded) d. ICF Shower throughout (corroded) e. skilled shower throughout (corroded)	K 353	K353 - Sprinkler System – Maintenance And Testing 1. **Corrective Action**: ADM or designee had contractor replace sprinkler heads in RM 19, RM 15, ICD Dining Room, ICF Shower room, Skilled Shower room. ADM or designee had contractor relocate sprinkler head in ICF Dining room. ADM or designee had contractor conduct a 5 year obstruction test and an air leakage test on the dry pipe sprinkler system and conduct a full flow trip test on the dry pipe sprinkler system and dry pipe sprinkler pendant test. 2. **Identifying other residents with potential to be affected**: All residents have the potential to be affected. 3. **Measures or Systemic Changes**: ADM or designee had contractor replace sprinkler heads in RM 19, RM 15, ICD Dining Room, ICF Shower room, Skilled Shower room. ADM or designee had contractor relocate sprinkler head in ICF Dining room. ADM or designee had contractor conduct a 5 year obstruction test and an air leakage test on the dry pipe sprinkler system and conduct a full flow trip test on the dry pipe sprinkler system. 4. **How corrective action will be monitored**: ADM or designee will do weekly audits x 4 weeks of random sprinkler heads. ADM or designee will develop a schedule for required inspections. The ADM or designee will then do monthly audits x 2 months. The results from the audits will be presented to the QAPI committee for further review. Any further issues or concerns will be addressed by the QAPI committee.	5/10/19

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K 353	Continued From page 4 NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.2.1.1.2 (2011 Edition) 2. Observation on 05/06/2019 at 8:27 PM, revealed a fire sprinkler within 4 inches of the wall in the ICF dining room. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 8.6.3.3 (2010 Edition), 3. Document review on 05/06/2019 between 9:00 PM and 9:45 PM, revealed no documentation for a fire sprinkler obstruction investigation within the last 5 years on all systems. The last investigation was completed in 2011. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 14.2.1 (2011 Edition) 4. Document review on 05/06/2019 between 9:00 PM and 9:45 PM, revealed no documentation for an air leakage test on the dry pipe sprinkler system within the last 3 years. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 13.4.4.2.9 (2011 Edition) 5. Document review on 05/06/2019 between 9:00 PM and 9:45 PM, revealed no documentation for for a full flow trip test on the dry pipe sprinkler system within the last 3 years. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 13.4.4.2.2.3 (2011 Edition) 6. Document review on 05/06/2019 between 9:00	K 353		

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K 353	Continued From page 5 PM and 9:45 PM, revealed no documentation for a dry pipe sprinkler pendant test within the last 10 years. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 5.3.1.1.1.6 (2011 Edition) The Maintenance Director and Facility Administrator was present for the findings and acknowledged them during the exit conference on 05/06/2019.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on an observation, the facility failed to maintain the fire extinguishers. This deficiency affected 1 of 16 smoke compartments and 0 residents. The finding included: Observation on 05/06/2019 at 8:04 PM, revealed the kitchen ABC fire extinguisher was blocked by carts. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.4.1 (2012 Edition), NFPA 10, 6.1.3.3.2 (2010 Edition)	K 355	K355 - Portable Fire Extinguishers 1. **Corrective Action:** ADM or designee removed the cart from blocking the fire extinguisher. Dietary staff was inserviced by ADM or designee to maintain clearance in front of the fire extinguisher. 2. **Identifying other residents with potential to be affected:** No residents had the potential to be affected. 3. **Measures or Systemic Changes:** ADM or designee placed caution tape on the floor in front of the fire extinguisher to alert staff the area should remain clear of any storage. 4. **How corrective action will be monitored:** ADM or designee will do weekly audits x 4 weeks of the fire extinguisher. ADM or designee will develop a schedule for required inspections. The ADM or designee will then do monthly audits x 2 months. The results from the audits will be presented to the QAPI committee for further review. Any further issues or concerns will be addressed by the QAPI committee.	6/19

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K 355	Continued From page 6 The Maintenance Director and Facility Administrator was present for the findings and acknowledged them during the exit conference on 05/06/2019.	K 355		

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E 000	Initial Comments Based on document review and interview on 05/06/2019, no Emergency preparedness deficiencies were cited	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adrienne Gatlin
TITLE: Administrator
(X6) DATE: 5/23/19

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